DEPARTMENT OF HUMAN SERVICES

FATALITY REVIEW REPORT

FY 2007

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DEPARTMENT OF HUMAN SERVICES
FATALITY REVIEW ANNUAL REPORT

JULY 1, 2006 – JUNE 30, 2007

EXECUTIVE SUMMARY

Department of Human Services (DHS) Fatality Review Policy requires a review of the deaths of all individuals for whom there is an open case at the time of death or in cases where the individual or their families have received services through DHS within twelve months preceding the death. Information obtained from case reviews provides insight into systemic strengths and highlights areas in which changes or modifications could enhance systemic response to client needs.

During FY 2007, one hundred thirty-four deaths of current or past DHS clients were reported to the Office of Services Review (OSR). There were four suicide deaths (3%) and six homicides (4.5%). The reviews indicate that abuse and/or neglect were contributing factors in ten (7%) of the one hundred thirty-four deaths. Eight children, 16% of fatalities reported by the Division of Child and Family Services (DCFS) died as the direct result of abuse or neglect by their parents/caretakers. The deaths of two individuals (3%) receiving services through the Division of Services to People with Disabilities (DSPD) are attributed to abuse or to failure on the part of the caregiver to follow safe practice procedures.

Of the fifty fatalities reported by DCFS, forty-three reviews were held (86%) with seven reviews pending. Sixty-one DSPD fatalities were reviewed (100%), and three of the four Division of Juvenile Justice Services (DJJS) fatalities were reviewed (75%) with one review pending. Utah State Developmental Center (USDC) conducted one on-site review (33%) with two reviews pending, and Utah State Hospital (USH) conducted four on-site reviews (100%). Three reported deaths from the Division of Aging and Adult Services (DAAS) met Department criteria for review, and three cases (100%) were reviewed. The Office of the Public Guardian (OPG) reported the deaths of thirteen individuals for whom they had provided services. Four of these individuals were also receiving services through DSPD or USDC at the time of their deaths. OPG provided comprehensive written reports covering services to all thirteen (100%) of its clients.

There were seventy-six (57%) reported deaths of male clients and fifty-eight (43%) reported deaths of female clients. Reported deaths included twenty-seven infants (20%) under the age of one year; thirty-eight (28%) clients between the ages of one to eighteen years; thirty-five (26%) clients between the ages of nineteen to fifty years; and thirty-four (25%) clients between the ages of fifty-one to ninety-nine years.

BACKGROUND and METHODOLOGY

In November 1999, the Office of Services Review (OSR) assumed responsibility for reviewing all DHS client fatalities. OSR recognizes the fatality review process as an opportunity to acknowledge good case management, to identify systemic weaknesses, to propose training for Division staff in performance problem areas, to involve Division staff on a local level in the review process, and to make cogent recommendations for systemic improvements.

The fatality review committees consist of a Board member of the Division under review, the Attorney General or designee for the Division, a member of management staff (supervisory level or above) from the designated Division and from a region other than that in which the fatality occurred, and in the case of a child fatality, the Director of the Office of the Guardian ad Litem or designee, a member of the Child Welfare Legislative Oversight Committee, and any individual whose expertise or knowledge could significantly contribute to the review process. Currently, the Child Fatality Review Committee is greatly strengthened by the membership of a pediatrician who is also a member of the DCFS Board, the DCFS State Training Coordinator, and a representative from the Division of Substance Abuse and Mental Health. Committee members have knowledge of DCFS Practice Guidelines and provide valuable insight into best-practice issues.

During the past year, the DCFS State Training Coordinator has joined the Child Fatality Review Committee. As the Committee identifies and discusses issues related to problems in practice, the Training Coordinator notes areas in the training curriculum that are in need of development or strengthening and, in conjunction with the training team, develops training to meet the identified need(s).

A representative from the Division of Substance Abuse and Mental Health also joined the Committee during FY 2007. He provides valuable insight into mental health and substance abuse issues and contributes information pertaining to substance abuse and mental health treatment resources.

The DSPD Fatality Review Committee utilizes the knowledge and expertise of two regional DSPD Registered Nurses who have on-going personal contact with many of the DSPD clients and who, in many cases, have first-hand knowledge of a decedent's medical history. Their medical knowledge and insight into health and safety issues is of great value to the non-medical committee members.

The Child Fatality Review Coordinator receives notification of client deaths through several channels, e.g., Deceased Client Reports, Certificates of Death, the State Medical Examiner, obituaries, emails, etc. In the case of child fatalities, the Coordinator receives Certificates of Death for every child who dies in the State of Utah. After researching the child welfare database, SAFE, to determine if the family has had services within twelve months of the fatality, the Coordinator requests and reviews the case file, summarizes the family's history of involvement, and makes an analysis pertaining to case practice and agency culpability.

Prior to the monthly DSPD and Child Fatality Review committee meetings, members are furnished with copies of fatality review reports, which they study while noting areas for discussion. When deemed appropriate, the Committees invite Division staff and/or contract providers to committee meetings to provide additional information. The fatality review reports, complete with committee concerns and/or recommendations, are then sent to the DHS Executive Director, the Director of the Division, and the Director of the region in which the fatality

occurred. The Region has fifteen days in which to formulate a reply and, if necessary, a plan of action for carrying out the committee's recommendations. Due to the low number of fatalities in the Division of Juvenile Justice Services, that committee meets on an as-needed basis.

As the result of an appeal to the Utah State Records Committee during FY 2007, DHS fatality review reports were reclassified from Protected/Protected to Private/Protected. The Records Committee determined that the content of the fatality report, i.e., the summary of services to the individual and/or his/her family should be classified as "Private". The Fatality Review Committees' analyses of concerns regarding practice and Committee recommendations to the Divisions remain classified as "Protected". Applicants must meet GRAMA criteria for these classifications in order to receive copies of fatality reports. In response to the reclassification of fatality review reports, the fatality review report's Executive Summary, which is available for public release, was redesigned to meet GRAMA criteria.

The DHS Fatality Review Coordinator represents the Department as a member of the State Child Fatality Review Committee, which is coordinated by the Department of Health's Violence and Injury Prevention Program (DOH/VIPP). The Child Fatality Review is a collaborative process including professionals from Primary Children's Medical Center's Safe and Healthy Families Team, the Birth Defects Network, the Office of the Medical Examiner, Emergency Medical Technician Services, law enforcement, the Office of the Attorney General, the Office of the Guardian ad Litem, the Children's Justice Division, the State Office of Education, the Department of Human Services, Valley Mental Health, the PCMC Child Advocacy Team, the Shaken Baby Foundation, and the Division of Child and Family Services.

The State Child Fatality Review Committee meets with the Utah State Medical Examiners on an as-needed basis to review the deaths of children whose deaths occur under violent, suspicious, unattended, or unknown circumstances and for children who have committed suicide. Committee members pool information regarding prior services to and/or involvement with the decedent/decedent's family, identify causes of preventable deaths, make Child Protective Services referrals, make recommendations for follow-up services when appropriate, identify interventions that could prevent future deaths, and provide information to law enforcement during child homicide investigations.

The State Child Fatality Review Committee has been instrumental in creating a Suicide Task Force, in partnering to complete a six-phase Youth Suicide Study, in working toward more comprehensive child restraint and seal belt legislation, and in developing news releases, public service announcements, and media events to address the most common injuries among Utah's children.

FINDINGS

As stated in the Department of Human Services Fatality Review Policy, "The purpose for reviewing a client death is to develop ways to prevent future client deaths and to improve Department services. The review itself evaluates the system's response to protecting vulnerable clients by assessing whether "best practice" was followed in the case. The Fatality Review Committee recommends modifications of procedures, policy, law, and training when necessary."

During FY 2007, the DHS Fatality Review Committees received reports of the death of one hundred thirty-four individuals who had received services through the Department within twelve months of their deaths. The Committees determined that in 132 cases (98.5%), services provided to the clients and/or their families did not contribute to the clients' deaths. In one DCFS fatality and in one DSPD fatality the client's death can be linked to failure on the part of workers or contract providers to follow best practice procedures.

> Best practice would dictate that a child suffering from suspected physical abuse be transported for medical examination by law enforcement or medical personnel. Or, if the parent is allowed to transport the child, the Child Protective Services worker would follow the parent to ensure that the child is taken to the medical facility. A two-year-old male died as the result of blunt force trauma to his abdomen and of "chronic child abuse" inflicted by his father. During the CPS investigation, DCFS gave permission for the father/suspected perpetrator to transport the toddler to a near-by hospital for a medical examination. Instead of complying, the father fled the state with his family, and the toddler died en route. The father eventually pleaded guilty to one count of second-degree felony child abuse homicide and was sentenced to fifteen years in prison. The boy's siblings were taken into protective custody.
>
> Best practice would dictate that contract provider staff secure all prescription medications immediately upon bringing them into a residence. A twenty-eight-year-old woman died from drug intoxication after taking the prescription medications intended for all of the residents of the group home in which the woman lived. After picking up multiple prescription medications from a pharmacy, staff placed the pills in an unlocked storage room until she made time to fill each individual's medication cassette. The decedent found the medications and ingested them all. The decedent had a history of suicide ideation and of engaging in self-injurious behaviors.

Of the fifty reported child fatalities eight deaths (16%) were attributed to abuse or neglect by a parent or caretaker. Of the sixty-one individuals who died while receiving services through DSPD and its contract providers, two deaths (3%) were related to abuse or negligence on the part of others.

The DHS Fatality Review Committee members identified numerous strengths in service-delivery systems that included noticeable improvement in child welfare's involvement of families in service planning; more aggressive seeking of appropriate kinship placements; and on the part of DSPD Support Coordinators, increased attention to the Health and Safety issues of their clients. Committee members also singled out several areas in which changes or modifications could enhance systemic response to the needs of Department clients that included better assessments of parents' and children's underlying needs, better matching of level of services to level of risk of harm, and better monitoring of contract providers. The reviewers also recognized several examples of outstanding case management conducted by Human Services staff.

DIVISION OF CHILD AND FAMILY SERVICES

SYSTEMIC STRENGTHS

In the majority of cases reviewed the quality of work conducted in Child Protective Services investigations and in providing on-going services to families continues to improve over casework conducted prior to the advent of the Practice Model. In the majority of cases reviewed workers saw the child within priority timeframes, conducted appropriate interviews, collaborated with law enforcement when necessary, worked with service providers to meet the needs of their clients, and if removal was necessary, were aggressive in seeking appropriate kinship or foster placements. With the advent of the Practice Model, caseworkers are conducting Child and Family Team Meetings and are working more closely with clients in an attempt to identify client needs and to plan appropriate services.

Committee members commended an on-call and an on-going CPS investigator for their excellent casework. These workers obtained appropriate assessments to determine the medical needs of the child, contacted the biological father who was living overseas and inform him of the CPS investigation, used valid case-investigation extensions to follow up on concerning issues and to monitor the parent's compliance, corroborated information provided by alleged perpetrators, staffed the case with supervisors and with the AAG to determine the appropriateness of filing court petitions, conducted kinship studies, and placed the children with appropriate relatives. These workers also provided the parents with excellent education on safe-sleeping practices and on maintaining a safe-sleep environment for their baby.

When a mother tested positive for methamphetamine use following the birth of her baby, the CPS worker acted quickly to insure the safety of a sibling by recommending that the court order Protective Supervision Services. While receiving PSS services, the mother again tested positive for drug use. The worker immediately took the child into protective custody and placed her with family members who had already been identified as an appropriate kinship placement. The relatives completed the requirements for licensure, and the worker assisted the mother in accessing an intensive, in-patient substance abuse treatment program. Concurrent permanency planning and a smooth, well-planned placement transition contributed to the child's well-being.

The parents of a baby born with severe birth defects recognized their limitations in caring for the baby and expressed that they did not want the baby's impending death to have an adverse affect on an older sibling. Rather than charging the parents with abandonment, the Division made a reasonable decision to support on an allegation of Dependency. The parents were given the opportunity to remain involved in making important decisions regarding the care and treatment of the baby. The permanency worker and the Hospice worker clarified the parents' wishes regarding the Do Not Resuscitate Order, provided emotional support for the foster parent, and assisted the parents in making the baby's funeral arrangements.

CPS and Permanency workers provided excellent services to parents after the birth of their daughter and did an outstanding job of assessing the family's ability to care for a medically fragile infant. The permanency worker coordinated services with the hospitals, Early Intervention, and the agency conducting the parents' mental health and parenting assessments. She kept the family informed of developments in the baby's treatment and explained to them options for her long-term care. The worker expressed concerns to the

hospital, the DCFS RN, the AAG, and the GAL about the quality of care the baby was receiving in the hospital's long-term care unit and explored options for better care.

SYSTEMIC WEAKNESSES

It should be noted that there were fifty DCFS fatalities reported in FY 2007, a number that is statistically insignificant when compared with the total number of DCFS cases open for services during that same time period. The systemic weaknesses and deviations from "best practice" casework identified by the Child Fatality Review Committee cannot be generalized to the child welfare system as a whole. However, several systemic problems have been noted in multiple cases. In the fifty reported DCFS client fatalities, the following issues raised the greatest concern among committee members. It is recommended that during FY 2008, DCFS concentrate on improving case practice in these areas.

Corroboration of Information

Child Protective Services Practice Guideline 203.1.D.1 states "Unless impossible or inappropriate, third party/collateral contacts having had direct association with the child/youth or who are otherwise knowledgeable about the case shall be interviewed." A systemic weakness identified at least eight of the thirty-nine cases reviewed (20.5%) by the Child Fatality Review Committee during FY 2007 was the seeming failure of some workers to interview third party/collateral contacts or to corroborate information given by parents and/or alleged perpetrators regarding their compliance in obtaining and participating in services. Although deviation from best practice did not directly result in the death of a child, it could have been a contributing factor in one case.

A family was the subject of four CPS referrals alleging non-supervision and physical neglect. One report was made by two school personnel and a DCFS staff member. However, the CPS worker did not interview any of the seemingly credible referents. The worker did not interview the children's uncle who reportedly was checking on the children each evening. The worker made only a cursory attempt to talk with the referent or to enlist her aid in setting up a meeting with the mother. The worker closed the case without ever meeting the mother and without ever entering the home to assess the children's safety and well-being. A child in the family died due to a non-supervision issue.

The worker in a voluntary in-home case conducted a thorough assessment of a mother's needs and of the mother's plans to access services. However, the worker did not contact providers at the Department of Workforce Services, Vocational Rehabilitation, the drug-testing agency, or the mental health agency to corroborate the mother's reports that she was following through with obtaining these services.

In a CPS investigation involving children with head lice the parents, who were separated, gave diametrically opposed statements about the whereabouts of one of the children during the period when she may have contracted lice. The father maintained that he had been out of state and that he had telephone records to prove that he had not had the child in his physical custody during that time. However, the worker did not ask to see the records to corroborate his statements.

Follow-through in Providing Services

In at least eight out of thirty-nine cases reviewed (20.5%) individuals or third-party collateral contacts furnished information to the caseworker indicating that the families were in need of services not directly related to the stated allegation. However, the workers did not address these

needs and did not offer services to the families. Cases were closed with inadequate or no services having been offered. In other cases the allegations of abuse and/or neglect were supported based on evidence gathered during the CPS investigation. However, the cases were closed with no services having been offered or provided to the family.

> A mother with a history of drug abuse and physically abusive relationships expressed interest in meeting with a DCFS Domestic Violence specialist. The CPS worker indicated that the DV specialist would contact the woman, but there was no documentation that the worker followed through with providing this service. The CPS case was kept open for five months with no follow-through on promised services.
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> A four-month-old infant died after suffering non-accidental injuries. Although the infant's mother was the prime suspect in law enforcement's criminal investigation, the infant's siblings, 2 and 4 years old, were left in the home. Before closing her case the CPS worker arranged for the family to receive a Family Preservation assessment. However, the assessment was never conducted, and the family was not referred for any type of service. For three months after the infant's death no services were provided to the family. DCFS did not monitor the safety and well-being of the siblings and did not coordinate its investigation with law enforcement.
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> CPS workers conducted excellent investigations into the reported abuse/neglect of a sibling group and provided services for the children after they were placed in the maternal grandmother's custody. The children's parents indicated several times that they would like help in improving their parenting and money management skills. After Child and Family Team members recommended that the parents could benefit from a parent advocate, the CPS worker made a referral for this service. However, there is no indication that the service was ever put in place, and there was no follow-up to ensure that the couple was accessing these services. Reunification efforts were missing in this case, as little was done on the part of the Division to help the parents gain skills necessary for them to provide a safe and appropriate home for their children.

Assessing Underlying Needs/ Level of Risk vs. Level of Services

In some cases workers followed all the practice guideline steps yet missed the mark as far as identifying the important underlying factors in the case and the underlying needs of the family members. Lack of a thorough assessment handicaps the worker's ability to provide appropriate services and can prolong a family's involvement with the Division when factors contributing to abusive and neglectful behaviors are not identified and addressed.

Some CPS investigations with supported allegations of abuse and/or neglect were closed with no services having been offered or provided to the family. In at least twelve of the thirty-nine cases reviewed (31%) the Committee noted that workers failed to make accurate and in-depth assessments of underlying needs, and by extension, failed to offer families/individuals an appropriate level of services. In cases involving medically fragile children or children with disabilities, the level of risk is higher and therefore, warrant a higher level of services.

> The mother of a child with multiple disabilities and with a history of drug abuse was receiving voluntary in-home services. She refused to drug test, falsified information given to the In-home worker, exhibited signs of possible depression, and admitted to the presence of drug paraphernalia in her bedroom. The young woman appeared to be in need of mental health treatment and/or medication management to address probable depression. There is the possibility that she was also in need of substance abuse

treatment. Rather than staffing the case for a PSS petition, the worker closed the case due to the mother's lack of cooperation, thus leaving the mother without support, oversight, or monitoring of her efforts to obtain help for her substance abuse issues and depression or assistance in finding employment or in securing appropriate housing.

A mother with a history of non-supervision and physical neglect worked long hours, leaving her children, one of whom was a developmentally-delayed eight-year-old, home alone in the care of their ten-year-old sister. Law enforcement, as well as CPS, had reported that the family lived in filth, without adequate power, heat, bedding, or clothing. Because the mother was difficult to contact, the most recent CPS investigation had been closed as "unable to complete" without the worker's having been inside the home to assess the validity of the report that the family was without heat during the middle of winter. No assessment of the children's health and safety needs was conducted, and no services were provided for the children. The mother's reported suicide threats and attempts were not addressed. The developmentally delayed child died several months later after choking on a small object while in the care of his sister.

Intake/Concerns

Child Protective Services Practice Guideline 201.4 states, "The CPS Intake process shall be completed by or staffed with a licensed social worker, with the exception of 'information only' contacts." Child Protective Services Practice Guideline 201.4.C states, "When there is an open CPS case and additional information in received, it is 'attached' to the open CPS case in the computer. The CPS caseworker is required to investigate any additional allegation that was not included with the initial case."

In at least nine of the thirty-nine cases reviewed (23%) the Committee noted concerns pertaining to reports of suspected abuse/neglect that appear to meet Practice Guidelines for acceptance but were unaccepted for investigation; of Intake or the CPS workers' having received additional information during CPS investigations which was not added to the CANR; of additional allegations of abuse/neglect having been made during an already-open CPS case but not having been added to the CANR or opened for investigation; and of additional information received by Intake not having been passed on to the CPS worker.

A grandmother reported two incidents in which her young grandson had been observed inappropriately touching his cousin. Grandmother expressed concern about the environment in which her grandson might have learned these behaviors, as his actions were highly suggestive of his having been exposed to inappropriate sexual conduct. The Intake worker suggested that the grandmother find a way to get the boy into therapy and suggested some non-leading ways for the grandmother to question him. However, the reports were unaccepted for investigation, and the boy received no services. Two years later there was another report of inappropriate sexual conduct between the boy and his cousin, and the boy was supported as the victim of sexual abuse by an unknown perpetrator.

A grandmother made a CPS report concerning domestic violence between her son and his wife, safety issues pertaining to where the mother and children were going to stay, and possible medical issues pertaining to a medically fragile child. However, the report was unaccepted for investigation. The reason documented for not accepting the report had no relationship to the stated allegations.

In two different cases reports of domestic violence related child abuse were not accepted for investigation even though the alleged perpetrators were arrested and were charged with domestic violence criminal mischief and domestic violence in the presence of a child. Intake's reason for not accepting one of the reports was that the incident was minor and that the family did not have a history of domestic violence.

During one CPS investigation, DCFS received at least four "additional information" calls. Although the CPS worker alluded to the information in her activity logs, no official reports were entered in SAFE as "additional information" or were opened as new CPS referrals.

Within a two-week period Intake received two reports of the suspected physical abuse of a two-year-old toddler by his father. The reports, from a social worker intern and from the child's mother, were unaccepted for investigation. Although the reports of alleged abuse, e.g., the father's being verbally abusive to the boy, of his making the child stand or sit on the toilet for hours at a time, of his having "flicked" the child on the arm on a regular basis, and of his having only recently learned that he was the boy's father, would have warranted a visual assessment of the child's well being, the Intake worker seems to have treated the CPS reports as a child custody/visitation issue and advised the mother to seek legal advice. Several months later the child died of injuries inflicted by his father.

DIVISION RESPONSES TO RECOMMENDATIONS

Regions have the opportunity to disagree with Committee recommendations and to explain their rationale for practice decisions. Regions are asked to submit an action plan to the Committee outlining the way they will implement Committee recommendations.

The DCFS Constituent Services Specialist tracks Child Fatality Review recommendations and ensures that regions are responding to the Committee. At the close of Fiscal Year 2007 regional responses to Child Fatality Review Committee concerns and/or recommendations were pending in only two cases. The Child Fatality Review Committee commends DCFS for the thoughtful and thorough responses the Regions and the Administrative Team have provided to the Committee's concerns and recommendations.

In response to the Committee's recommendation that based on a family's history of Domestic Violence related child abuse the case be staffed to determine the appropriateness of filing a PSS petition, the State Constituent Services Specialist replied that she staffed the case with the State DV Specialist and requested that the Salt Lake Valley Region staff the case to re-examine the safety of the children remaining in the home. The State DV Specialist agreed to work with the region and to follow up on the Fatality Review Committee's concerns. The Region responded,

> "A staffing was held. In the staffing with the AAG's office it was determined that there was not enough evidence to get a PSS petition. However, the mother has since moved into the YWCA. A worker is providing CIS (Counseling Individual Services) to support the family."

In response to Committee concerns regarding the role of Family Advocates in CPS investigations, Northern Region submitted a proposal to the State Office outlining the Region's plan for containing "most of the complaints and concerns within the region" originating from Family Advocates. The plan included monthly meetings with the Advocates to establish a relationship and provide a forum in which issues and concerns could be discussed that were not in need of

immediate attention and addressed additional training for supervisors and staff on improving teaming and coordination skills and on increasing their knowledge of DCFS Practice Guidelines.

The addition of the DCFS State Training Coordinator to the Child Fatality Review Committee has provided a conduit through which the Committee's practice concerns are translated into improved training curricula and, hopefully, improved practice. Child Fatality Review Committee members recognize that the Division receives recommendations for practice improvement from many different sources. However, it is highly gratifying to see concrete steps being taken to address some of the committee's long-standing concerns. During FY 2007, the following action has been developed or is in the process of being developed by the State Training Team:

- A web training site is in the process of being developed that will include already-developed information on safe sleeping practices for infants. Additional information pertaining to child vulnerability or to issues that might impact a child's safety will be added to the website as needs are identified.

- Safety information for parents that mirrors information for caseworkers will be made available on the DCFS website.

- Training on Safety Model concepts will be available in the fall of 2007. The model emphasizes the assessment of a child's safety as being central to Intake and CPS workers' decision making and vital in visiting and reunification decisions made by on-going workers. The training will provide language for caseworkers to use in talking about safety, additional information on assessing for safety, and an emphasis on making continual assessments for safety throughout the life of a case.

- Handbooks are being developed that cover tasks related to Intake and CPS. The first handbooks will be for supervisors, Transition to Adult Living, Intake, Purposeful Visiting, and Child Protective Services. The Purposeful Visiting handbook will address the need for the worker to make a safety assessment at every home visit. Each handbook will address all tasks required in a specific service area that facilitate a worker's implementing best practice methods and meeting practice guideline requirements.

- The gap in CPS training provision is being addressed currently with a module on Child Interviewing that is based on recent research. A CPS and Intake training that uses the Safety Model and that covers all aspects of practice in the program area is also planned.

- The Practice Model Assessing module is being revised to include specific information on maltreatment and safety and how workers would assess these factors.

- Secondary Traumatic Stress training is being constructed to assist caseworkers in addressing the trauma that they experience in their work with victims of abuse and neglect.

- A fatality review section will be added to the New Employee training curriculum to provide perspective on this process for new caseworkers.

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

COMMUNITY PLACEMENTS

SYSTEMIC STRENGTHS

DSPD Support Coordinators act as advocates for individuals who are receiving services through the Division and through its contract providers. They verify and provide appropriate documentation necessary for ensuring an individual's eligibility for waivered services, provide crisis intervention when necessary, monitor the delivery and appropriateness of contracted services, review monthly provider reports, and assess an individual's well-being through in-person visits in the home or at the day support site. The DSPD Fatality Review Committee recognized the excellent work of several Support Coordinators and recommended that they be commended for their outstanding work.

Staff from several contract providers were recognized by the Committee for their excellence in caring for individuals and for their exceptional efforts to provide comfort to individuals suffering from terminal medical conditions. Staff from United Cerebral Palsy, Danville Services, Futures through Choices, Frontline Services, TURN Community Services, and Chrysalis were commended for their outstanding work.

The DSPD RN's provide an excellent resource for Support Coordinators in dealing with the health and safety issues of individuals in service. Many of the individuals receiving services through DSPD and its contract providers are diagnosed with numerous medical and/or behavioral problems for which they receive treatment and prescription medication. Individuals who are immobile are subject to skin breakdown that can lead to serious, and even life-threatening, wounds. RN's visit with individuals in their homes, in hospitals, and in care centers to make assessments of their medical condition and to monitor their progress and the quality of care they are receiving. The RN's have knowledge of prescription medications, their uses and possible side effects and can monitor the effectiveness and/or appropriateness of these medications. In some instances the RN's act as a liaison between medical professionals and providers, family, and DSPD, and they participate with hospital personnel in discharge planning.

Recently, Southern Region acquired a second RN to provide coverage for individuals from south of the Wasatch Front to the southern-most areas of the state. Service to Support Coordinators and individuals has been enhanced by having an RN located in that geographical area. The Committee recognizes the excellent work of the DSPD RN's in all regions.

> A terminally-ill woman who was receiving Community Living Support services through United Cerebral Palsy (UPC) was provided the opportunity to die with dignity at home. Staff provided excellent care in facilitating the healing and prevention of wounds incurred from skin breakdown. They coordinated services with Hospice, provided an opportunity for Hospice staff to instruct UPC group home staff and the group home residents on what to expect during the woman's dying process, and honored the woman's request to return home to die in familiar surroundings in the company of family and friends.
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> An individual and his roommate were living in a Supported Living apartment provided by Danville Services. While the man's roommate was hospitalized and in rehab, Danville Services staff stopped in often to spend time with the individual at times other than their three contracted visits per week. The Residential Manager telephoned the

individual each day to determine that he had arrived home safely from his day program and to insure that the man was eating dinner.

Frontline's behavior specialist wrote a behavior protocol specifically designed for the work environment of a woman who was demonstrating many behavioral issues at her work site and provided training on the protocol to day support staff. This plan, when followed correctly, worked well in decreasing the incidence of the woman's maladaptive behaviors.

During the months of a woman's hospitalization, rehabilitation, and subsequent hospital admissions, Danville Services staff were actively involved in monitoring her progress and in planning to meet her needs at time of discharge. Danville made arrangements to move the woman into a wheelchair-accessible apartment. The Office of the Public Guardian assisted the woman's family in having a family member appointed as her legal guardian. Danville and the OPG worked closely with hospital and skilled nursing facility staff to monitor the woman's medical situation, and they kept her family fully informed of her needs. After the woman's discharge to the rehabilitation facility Danville staff continued to visit her, assist with her feedings, and provide emotional support.

Chrysalis staff provided excellent care to a man and his family during the man's illness. Staff visited the home and provided respite for the primary caretaker. Their service allowed the man to remain in his mother's home during the final weeks of his life.

The Committee commended a Support Coordinator for the positive relationship that he developed with a young Native American man and for the feelings of trust that he engendered in the youth. The Support Coordinator, who speaks the Navajo language and is familiar with Navajo culture, was well matched for working with the young man and his family.

SYSTEMIC WEAKNESSES

Although the DSPD Fatality Review Committee noted some concerns related to the delivery of provider services, there were no obvious systemic-weakness trends in the DSPD cases reviewed during FY 2007. The level of care for individuals appears to have been appropriate and provided as contracted. Individuals were provided with multiple services, excellent medical, dental, and mental health care, and opportunities to participate in meaningful work and community and social activities. Provider staff worked with several individuals in planning and shopping for nutritious meals and in encouraging them to exercise in order to reach or maintain a healthy weight. Nine children and two adults were able to be cared for in their homes by family with the help of respite services. However, in several of those cases the individuals had been on the waiting list for services for several years and had become eligible for services shortly before their deaths.

Miscellaneous Concerns

Some of the concerns noted by the Committee included the possible financial exploitation of an individual by his host home parents. The Bureau of Internal Review and Audit (BIRA) is currently investigating this matter. It was also noted that the provider had not submitted mandatory monthly reports to the Division.

A woman from Northern Region who fractured her knee was hospitalized at the University of Utah Medical Center in Salt Lake City and was scheduled for knee surgery. The Futures through Choices Program Coordinator provided hospital staff with extensive information about the woman's medical history, and he or another staff member made daily trips to the hospital to

monitor her progress. The Program Coordinator informed the hospital that the woman would be returning to the group home unless she required a higher level of care than staff was able to provide. In that case she would be released to a skilled nursing facility in Brigham City. In response to the Program Coordinator's telephone call, hospital staff reported that the woman had done well in surgery. Later that day FTC staff reported that the surgery had been postponed for several days. When the Program Coordinator arrived at the hospital to transport the woman to Brigham City, he found that she had been released to an unidentified individual. The man was eventually identified as staff from the Brigham City nursing home, and the woman had been transported and admitted to that facility without the knowledge of DSPD or of Futures through Choices. The Northern Region RN reported that she had not been informed that the individual had been hospitalized. Otherwise, she could have coordinated discharge planning with the hospital, thus preventing the individual's release to an unauthorized person. The Northern Region RN has provided support coordinators with a procedure for coordinating the discharge of an individual from a hospital.

A woman was admitted to the hospital for emergency surgery to repair a perforated stomach. After the woman's doctor indicated that he did not think she would survive, attempts were made to reach the woman's legal co-guardian but with no success. The parents (co-guardians) made the decision to remove life support, and the woman died shortly thereafter. It was unclear if provider staff had alternative telephone numbers for the guardian. The Committee questioned if there was a backup guardian who could make medical decisions in the event that the legal guardian could not be reached during a medical emergency. The provider indicated that the issue of establishing a backup protocol and a "calling tree" for all individuals in their services who have court-appointed guardianship would be addressed with the agency's management team.

Casework Documentation

The problem most frequently noted by the Committee dealt with Support Coordinator Activity Log documentation. In five of the sixty-one cases (8%) the Committee noted deficiencies in the recording of caseworker activities. One worker "cut and paste" log entries from month to month with little or no change in the content. When the client's circumstances changed, these log entries provided false information. The Committee also recommended that the supervisor be reminded that it was his responsibility to review activity logs for accuracy and to train staff in activity documentation.

Another worker "cut and paste" the lengthy monthly provider reports into his logs. It was recommended that he include a brief summary rather than the entire report. Another worker failed to document medical orders and follow-up in her logs, which lead to the appearance of medical neglect on her part. The worker was trained on appropriate documentation of such orders.

Another Support Coordinator appeared to have violated DSPD and Medicaid policy by not recording a quarterly face-to-face visit with an individual. When questioned, the worker showed that he had recorded face-to-face visits with the family in brother's log but had failed to record them in this individual's record. The worker acknowledged the oversight.

Provider Negligence

In one case ((2 %) negligence on the part of a contract provider appears to have directly contributed to the death of an individual.

> A twenty-eight-year-old woman died from drug intoxication after taking the prescription medications intended for all of the residents of the group home in which the woman

lived. After picking up multiple prescription medications from a pharmacy, staff placed the pills in an unlocked storage room until she made time to fill each individual's medication cassette. The decedent found the medications and ingested them all. The decedent had a history of suicide ideation and of engaging in self-injurious behaviors.

Reporting of Fatalities

During FY 2007, there was a breakdown in the Division's reporting of fatalities to the DHS Fatality Review Coordinator. At least one-third of the sixty-one fatalities were not forwarded to the Fatality Review Coordinator in a timely manner. The problem surfaced when DSPD administration compared their records with the fatality review database and discovered that a number of deceased individuals were not included in the database nor had their cases been reviewed. Because the DHS Fatality Review Coordinator receives the Deceased Client Reports from DSPD administration, it is imperative that these reports be forwarded as soon as they are received.

It is concerning that the Deceased Client Report for the case in Southern Region pertaining to the individual who died after taking the group home residents' prescription medications was never sent to the Fatality Review Coordinator. She was made aware of the death by the Region RN but was never notified by the region or by administration.

DIVISION RESPONSES TO RECOMMENDATIONS

The DSPD Regional Directors are to be commended for their prompt and serious consideration of committee recommendations, for the action that they initiate to comply with recommendations, and for their formal written responses to the Fatality Review Committee. Two Committee recommendations were directed to DSPD administration, but there has been no response to either of the following recommendations.

It was recommended that DSPD administration make written communication with UTA asking them to train and/or remind FLEXTRAN drivers to communicate any concerns, health or behavioral, they have about those individuals to provider staff as the individual exits the bus.

It was also recommended that DSPD administration consider putting additional language in provider contracts requiring them to provide a detailed procedure for reaching an individual's legal guardian or a backup guardian in the event of a medical emergency.

UTAH STATE DEVELOPMENTAL CENTER

The deaths of three individuals were reported by the Utah State Developmental Center. One individual died at the University of Utah Medical Center, Salt Lake City, Utah, of Chronic Subdural Hemorrhage due to Tuberous Sclerosis. A formal death review was held for this individual at USDC.

Failure to Thrive is listed as the cause of death for a second individual who was living at a care center in Salt Lake City, and a third individual died at USDC as the result of a Seizure Disorder. The fatality reviews for these individuals are pending.

DIVISION OF AGING AND ADULT SERVICES

During FY 2007, there were three reported fatalities from the Division of Aging and Adult Services that met DHS fatality review criteria. Two individuals died of pneumonia, one at home and the other in a hospital, and the third individual died of exposure.

DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

UTAH STATE HOSPITAL

During FY 2007, Utah State Hospital reported the deaths of four people who were currently receiving or who had received services within ninety days of their deaths. An individual who was receiving in-patient treatment at USH died of cancer. The individual suffered from a number of medical problems including a malignant neoplasm of the prostate, a neuroendocrine tumor in the large intestine, and an umbilical hernia. He received excellent medical care for these conditions while at USH including consultations with medical specialists. After deciding against treatment for the more recent diagnosis of the tumor in the large intestine, the individual was assigned a Hospice caseworker.

A second individual died of an Acute Myocardial Infarction at a care center in Salt Lake City, Utah. He had been hospitalized at USH for over a year before being discharged to the care center. The individual was diagnosed with, among other things, Dementia due to Medical Condition with Behavioral Disturbance. He received excellent psychiatric and medical care while a patient at USH.

A third individual died of Congestive Heart Failure at a care center in Heber, Utah. She had psychiatric diagnoses in addition to several medical diagnoses. While a patient at USH, the individual received quality treatment for psychiatric issues, as well as for medical issues.

The fourth individual died in an auto/pedestrian accident on an Interstate highway in Utah, and his death has been ruled a suicide. The man was referred to USH for treatment as not competent to proceed for criminal charges. After undergoing medication changes and adjustments the individual was eventually found competent, was placed on probation, and was released to the community. After discharge from USH the individual was referred for mental health services. Although he contacted mental health, he did not set an appointment before his death.

The Utah State Hospital Clinical Director and the Clinical Risk Manager conducted on-site Risk Management Fatality reviews for each case. Due to the reclassification of DHS Fatality Review reports as Private, which creates the possibility of HIPPA violations, USH no longer provides DHS with reports of its reviews.

DIVISION OF JUVENILE JUSTICE SERVICES

The Committee received notification of the fatalities of four Division of Juvenile Justice Services (DJJS) clients. The manner of death of one youth is listed as "undetermined" with the cause of death being drug poisoning. The youth, who was in JJS custody at the time of his death, was on a home placement. The manner of death of the second youth, who was in an Independent Living placement, is listed as an "accident" with the cause of death being drowning. The third youth's death was certified a suicide with the cause of death being a gunshot wound. The youth had recently begun a home placement. A fourth youth died of a staph infection while participating in a wilderness program.

SYSTEMIC STRENGTHS

In the cases reviewed by the Fatality Review Committee, youth in DJJS custody received intensive assessments and services that included individual and group therapies, medication management, life skills training, substance abuse treatment programs, educational services, and tracking. Case managers and trackers were diligent in monitoring the well-being and compliance of their clients.

SYSTEMIC WEAKNESSES

Due to the low number of cases reviewed for DJJS, the Committee did not identify any practice concerns or systemic weaknesses.

OFFICE OF THE PUBLIC GUARDIAN

During FY 2007, the Office of the Public Guardian reported the deaths of thirteen individuals for whom they had provided guardianship services. Three clients were also receiving services in community placements through the Division of Services for People with Disabilities. and one client was receiving services through the Utah State Developmental Center. Six individuals were hospitalized at the time of their deaths, and seven individuals died in care centers. The manner of death for all clients was "natural causes". The OGP provided the Fatality Review Coordinator with comprehensive summaries of the clients' service histories and with an explanation of the causes of death. It appeared that all decedents received appropriate services and that their deaths were related to age and medical conditions.

DEPARTMENT OF HUMAN SERVICES
FATALITY REPORT

SUMMARY
FY 2007

DEPARTMENT/DIVISION	Number of Reported Deaths	Cases Open at Time of Death	Cases Reviewed	Reviews Pending	Male	Female
DEPARTMENT OF HUMAN SERVICES	**134**	**101**	**124**	**10**	**76**	**58**
DAAS ***(Division of Aging and Adult Services)***	3	2	3	0	1	2
DCFS ***(Division of Child and Family Services)***	49	21	42	7	22	27
DCFS/DSPD *(Division of Child and Family Services/Division of Services for People with Disabilities)*	1	0	1	0	1	0
DJJS *(Division of Juvenile Justice Services)*	3	3	3	0	2	1
DJJS/DCFS *(Division of Juvenile Justice Services/ Division of Child and Family Services)*	1	1	0	1	1	0
DMH - USH ***(Division of Mental Health - Utah State Hospital)***	4	2	4	0	3	1
DSPD – COMMUNITIY PLACEMENT ***(Division of Services for People with Disabilities)***	56	56	56	0	37	19
DSPD/DCFS *(Division of Services for People with Disabilities/Division of Child and Family Services)*	1	1	1	0	1	0

SUMMARY - Continued

DEPARTMENT/DIVISION	Number of Reported Deaths	Cases Open at Time of Death	Cases Reviewed	Reviews Pending	Male	Female
DEPARTMENT OF HUMAN SERVICES	**134**	**101**	**124**	**10**	**76**	**58**
DSPD/DSA/MH *(Division of Services for People with Disabilities/Division of Substance Abuse and Mental Health)*	1	1	1	0	0	1
DSPD/OPG *(Division of Services for People with Disabilities/Office of the Public Guardian)*	3	3	3	0	2	1
USDC *(Division of Services for People with Disabilities – Utah State Developmental Center)*	2	1	1	1	2	0
USDC/OPG *(Utah State Developmental Center/Office of the Public Guardian)*	1	1	0	1	1	0
OPG *(Office of the Public Guardian)*	9	9	9	0	3	6

CHART I

FIVE-YEAR COMPARISON

FY 2003 – FY 2007

	FY 2003	FY2004	FY 2005	FY 2006	FY2007
DHS Reported Deaths	106	95	106	100	134
DAAS	0	1	1	0	3
DCFS	50	35	40	31	49
DCFS/DSPD	1	2	1	1	1
DJJS	5	1	7	2	3
DJJS/DCFS	0	0	0	1	1
DMH - USH	7	6	2	2	4
DSPD	29	39	43	57	56
DSPD/OPG	0	0	0	0	3
DSPD - USDC	5	8	5	3	3
DSPD/DMH	1	0	0	0	1
OPG	7	3	7	3	9
Cases Open at Time of Death	70	66	76	79	101
Reviews Held	96	92	101	97	124
Abuse & Neglect Deaths	6	9	5	6	11
Accidental Deaths	21	10	13	8	15
Homicides	5	3	4	3	5
Motor Vehicle Related Deaths	14	2	8	3	5
Suicides	11	2	9	1	4

CHART II

AGE AT TIME OF DEATH

FY 2007

AGE IN YEARS	DHS	DAAS	DCFS	DCFS/ DSPD	DJJS	DJJS/ DCFS	DSPD	DSPD/ DCFS/ OPG	DSPD/ DSA/ DMH	DSPD/ OPG	OPG	USDC	USDC/ OPG	USH
< 1	27		27											
1 – 3	9		9											
4- 6	2		2											
7- 10	9		4				5							
11 - 14	7		1	1			5							
15 - 18	11		6		3	1	1							
19 - 30	7						5	1	1					
31 – 50	28	1					21			2	1	2		1
51- 65	20						15			1	1		1	2
66 – 80	10	1					4				4			1
81 - 90	2										2			
91 - 100	2	1									1			
TOTALS	134	3	49	1	3	1	56	1	1	3	9	2	1	4

CHART III
SUICIDE DEATHS
FY2007

MANNER OF SUICIDE	GENDER	AGE	DIVISION
Asphyxia (Hanging)	Male	21	DSPD
Auto/Pedestrian	Male		USH
Exit from Moving Vehicle	Male		DCFS
Gunshot Wound	Male		DJJS
TOTAL - 4			

CHART IV
HOMICIDE DEATHS
FY2007

MANNER OF HOMICIDE	GENDER	AGE	DIVISION
Gunshot Wound	Female	15	DCFS
Inflicted Trauma	Female	4 months	DCFS
	Male	2	DCFS
Abusive Head Injury from Shaken Baby Syndrome	Male	20	DSPD/DCFS
Strangulation	Female	3 months	DCFS
	Female	15	DCFS
TOTALS	6		

CHART V
ACCIDENTAL DEATHS
FY2007

CAUSE OF DEATH	GENDER	AGE	DIVISION
Asphyxiation	FEMALE	5 months	DCFS
	MALE	7	DCFS
	MALE	60	DSPD
Blunt Force Injuries to the Head/Traumatic Brain Injury	MALE	2	DCFS
	FEMALE	3	DCFS
	MALE	13	DCFS
	MALE	13	DCFS/DSPD
	MALE	33	DSPD
Drowning	FEMALE	10 months	DCFS
	FEMALE	12 months	DCFS
	MALE	14 months	DCFS
	MALE	18	DJJS
Smoke Inhalation/Conflagration Injuries	Male	14 months	DCFS
	Male	2	DCFS
	Female	4	DCFS
TOTALS	15		
Males	12		
Females	3		

CHART VI
ABUSE/NEGLECT DEATHS
FY 2007

CAUSE OF DEATH	DHS	GENDER	AGE	DIVISION
Traumatic Head Injury	1	Male	13	DCFS/DSPD
	1	Male	20	DSPD/DCFS
Asphyxia	1	Male	8	DCFS
	1	Female	3 months	DCFS
	1	Female	5 months	DCFS
Drowning	1	Female	10 months	DCFS
	1	Female	1	DCFS
Drug Intoxication	1	Female	28	DSPD
Inflicted Injuries	1	Female	4 months	DCFS
	1	Male	2	DCFS
Smoke Inhalation	1	Male	13 months	DCFS
TOTALS	11			

CHART VII
MEDICAL EXAMINER'S DETERMINATION
MANNER OF DEATH
FY 2007

MANNER OF DEATH	DHS	DAAS	DCFS	DJJS	DSPD	OPG	USDC	USH
Accident	16		13	1	2			
Homicide	5		4		1			
Natural Causes	94	2	22	1	54	9	3	3
Pending	3		2		1			
Suicide	4		1	1	1			1
Undetermined	12	1	8	1	2			
TOTALS	134	3	50	4	61	9	3	4

CHART VIII
FATALITIES BY REGION AND OFFICE
FY2007

DIVISION OF AGING AND ADULT SERVICES

REGION	TOTAL	OFFICE	TOTAL
Central	3		
		Holladay	3
TOTAL	3		3

DIVISION OF CHILD AND FAMILY SERVICES

REGION	TOTAL	OFFICE	TOTAL
Eastern	4		
		Price	2
		Roosevelt	1
		Vernal	1
Northern	12		
		Bountiful	2
		Logan	1
		Ogden	8
		Brigham City	1
Salt Lake Valley	23		
		East Jordan Neighborhood	1
		Fashion Place	1
		Jackson	4
		Magna	1
		Oquirrh Neighborhood	11
		Salt Lake West	1
		South Town	1
		Tooele	1
		West Jordan	2
Southwest	5		
		Cedar City	1
		St. George	4
Western	6		
		Heber City	1
		Nephi	1
		Provo	2
		Spanish Fork	2
TOTAL	50		50

CHART VIII – Continued

DIVISION OF JUVENILE JUSTICE SERVICES

REGION	TOTAL	OFFICE	TOTAL
Region I	1		
		Ogden	1
Region II	2		
		Salt Lake	2
Region III	1		
		Price	1
TOTAL	4		4

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

REGION	TOTAL	OFFICE	TOTAL
Central	26		
		Administration	4
		Heber City	3
		Holladay	18
		Vernal	1
Northern	11		
		Clearfield	3
		Logan	1
		Ogden	5
		SLC - State Street	2
Southern	24		
		American Fork	4
		Blanding	2
		Moab	1
		Nephi	3
		Price	2
		Provo	3
		Spanish Fork	3
		St. George	6
USDC	3		
		American Fork	3
TOTAL	64		64

CHART VIII - Continued

DIVISION OF SUBSTANCE ABUSE and MENTAL HEALTH

REGION	TOTAL	OFFICE	TOTAL
USH	4		
		Provo	4
TOTAL	4		4

OFFICE OF THE PUBLIC GUARDIAN

REGION	TOTAL	OFFICE	TOTAL
Northern	2		
Salt Lake	7		
Southwest	2		
Utah Valley	2		
		Administration	13
TOTAL	13		13